203 CLAIMS PROCESSING

REVISION DATE: XX-XX-XXXX
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 36-2903.01~~.~~(G)~~,~~; 36-2904.G; 42 § C.F.R. 438.242(a)~~,~~ 45 §§ C.F.R. 160.101 et seq., 162.100 et seq.~~,~~ and 164.102 et seq.~~,~~; AHCCCS Contract; Section F3 Contractor Chart of Deliverables
~~DELIVERABLES: Claims Dashboard~~

PURPOSE

This policy outlines the ~~applies to the Division's Administrative Services Subcontractors (AdSS). It stipulates~~ requirements for the adjudication and payment of claims for the Division's Administrative Services Subcontractors (AdSS). ~~See Section F3, Contractor Chart of Deliverables.~~

DEFINITIONS

~~A~~1. "Administrative Services Subcontract~~s~~" means ~~An Administrative Services Subcontract is~~ a contract that delegates any of the requirements of the Division's contract with AHCCCS.~~, including, but not limited to the following: 1. Claims processing, including pharmacy claims, 2. Pharmacy Benefit Manager (PMB), 3. Dental Benefit Manager, 4. Credentialing, including those for only primary source verification (i.e., Credential Verification Organization [CVO]), 5. Management Service Agreements, 6.~~

~~Medicaid Accountable Care Organization (ACO), 7. Service Level Agreements with any Division or subsidiary of a corporate parent owner, and 8. CHP and DDD Subcontracted Health Plan.~~

~~1.Claims processing, including pharmacy claims~~

~~2. Credentialing, including those for only primary source verification~~

~~3. Management Service Agreements~~

~~4. Service Level Agreements with any Division~~

~~5. Subsidiary of a corporate parent owner claims process.~~

2~~B~~. "Clean Claim" means ~~–~~ A~~a~~ claim that may be processed without obtaining additional information from the Provider~~provider~~ of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. § 36-2904.

3. "Medicaid National Correct Coding Initiative Edits" means correct billing code methodologies set by the Centers for Medicare and Medicaid Services that are applied to claims to reduce improper coding and thus reduce improper payments of claims.

4. "Member" means the same as "client" as defined by A.R.S. § 36-551.

5. "Provider" means a person, institution, or group engaged in the delivery of services, or ordering and referring those services, who has an agreement with AHCCCS to provide services to AHCCCS members.

6. "Receipt Date" means the day a claim is received at the AdSS's specified claim mailing address or received through direct electronic submission to the AdSS's electronic claims processing system or received by the AdSS's designated clearinghouse.

7.~~C~~. "Subcontractor" means ~~—~~

~~1.~~ a. A Provider~~provider~~ of health care who agrees to furnish covered services to M~~m~~embers; or

~~2.~~ b. A person, agency or organization with which the ~~Administrative Services Subcontractor (~~AdSS~~)~~ has contracted or delegated some of its management/administrative functions or responsibilities; or

~~3.~~ c. A person, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease

(or leases of real property) to obtain space, supplies, equipment, or services provided under the Division agreement.

A. CLAIMS PROCESSING SYSTEMS REQUIREMENTS

~~**Claims Processes and Systems**~~

1. The AdSS shall~~must~~ develop and maintain claims processes and systems that ensure the accurate ~~correct~~ collection and processing of claims, analysis, integration, and reporting of data.
2. The AdSS shall ensure that ~~These~~ claims processes and systems generate~~result in~~ information pertaining to the following ~~on~~ areas~~: including, but not limited to,~~
   a. S~~s~~ervice utilization~~,~~;
   b. c~~C~~laim disputes~~;, and~~
   c. Member grievances and appeals~~.~~; and
   d. Disenrollment for reasons other than loss of Medicaid eligibility.
2. The AdSS shall ~~must have a mechanism to~~ inform Provider~~provider~~s of the appropriate place to send claims at the

time of notification or prior authorization using the following mechanisms:

a. ~~-~~The AdSS subcontract;

b. The AdSS Provider~~provider~~ manual;

c. The AdSS website; or

d. Other Provider~~provider~~ platforms.~~if the provider has not otherwise been informed of such information via subcontract and/or a provider manual.~~

~~**Receipt Date**~~

3. The AdSS shall recognize t~~T~~he R~~r~~eceipt D~~d~~ate of the claim as ~~is~~ the ~~date of the~~ date stamped on the claim, or the date ~~on which~~ the claim is electronically received by the AdSS. ~~The receipt date is the day on which the claim is received at the AdSS specified claim mailing address, received through direct electronic submission, or received by the AdSS designated clearinghouse.~~

~~**Claim Submission Timeliness**~~

B. CLAIM TIMELY FILING, PAYMENT, AND REPORTING REQUIREMENTS

1. ~~A. Unless a contract specifies otherwise, t~~The AdSS shall adjudicate claims ~~ensures that,~~ for each form type as follows, unless a subcontract specifies otherwise:

   a. ~~,~~ 95% of all ~~c~~Clean C~~c~~laims ~~are adjudicated~~ within 30 days of receipt of the C~~c~~lean C~~c~~laim; and

   b. 99% of all Clean Claims~~are adjudicated~~ within 60 days of receipt of the C~~c~~lean C~~c~~laim.

2. The AdSS shall ensure 95% of Clean Claims reach paid status on a Provider~~provider~~'s first billing submission.

3. The AdSS shall ensure less than 20% of a Provider~~provider~~'s second submission of claims are denied.

4. The AdSS shall ~~must track and report~~ submit a report to the Division with the following Clean Claim payment or claim payment denial information monthly:

   a~~1~~. Percentage of C~~c~~lean C~~c~~laims that reach paid~~PAID~~ status on a Provider~~provider~~'s first billing submission.

~~The AdSS will ensure that 95% of all clean claims reach PAID status on the provider's first billing submission.~~

i. The AdSS shall~~will~~ highlight the appropriate field in the report and provide an explanation if the paid status percentage of Clean Claims ~~this~~ falls below the contract performance minimum of 95%.

b~~2~~.~~-~~ Percentage of claims that are denied, calculated by dividing the total number of claims denied in the month by the total number of claims processed in the month.

~~DENIED~~

i. The AdSS shall~~will~~ highlight the appropriate field in the report and provide an explanation if the total percentage of denied claims reported is above 20%; or ~~OR~~

ii. The AdSS shall~~will~~ highlight the appropriate field in the report and provide an explanation if there is a 15% increase of denied claims from the previous reporting month.

~~*For example, if the previous month's percent claims denied was 10%, the AdSS must provide an explanation if the current month's percent is 11.5% or greater.*~~

~~Percentage of claims denied:~~

~~Total number of claims denied in the month~~

~~Total number of claims processed in the month~~

~~B. In addition, 95% of clean claims will be paid on first submission and less than 20% of second submission claims will be denied.~~

5~~C~~. ~~-~~ The AdSS shall~~must~~ refer to Attachment~~ATTACHMENT~~ B of the DDD Claims Dashboard Reporting Guide for additional ~~information on~~ reporting guidelines.

6. The AdSS shall~~must~~ not pay claims~~:~~

a~~A~~. ~~Claims i~~Initially submitted more than six months after the date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later; or

b.~~B~~. Claims submitted as C~~c~~lean C~~c~~laims more than 12 months after the date of service for which payment is claimed or

after the date that eligibility is posted, whichever date is later.

7. Regardless of any subcontract with an Arizona Health Care Cost Containment System (AHCCCS) Managed Care Organization (MCO), if one MCO recoups a claim because the claim is the payment responsibility of another AHCCCS MCO, the Provider may file a Clean Claim for payment with the responsible MCO.

8. If the Provider~~provider~~ submits a Clean Claim to the responsible MCO, the Provider shall do so not later than the following timelines:

a. 60 days from the date of the recoupment;

b. 12 months from the date of service; or

c. 12 months from the date that eligibility is posted; whichever date is later. ~~When any payor recoups a claim because the claim is the payment responsibility of another payor (responsible payor), the provider may file a claim for payment with the responsible payor. The provider may must submit a Cclean Cclaim to the responsible payor no later than the latest of the following dates:~~

~~a~~A. ~~60 days from the date of the recoupment;~~

~~b~~B. ~~12 months from the date of service,~~

~~cC. 12 months from the date that eligibility is posted, whichever date is later.~~

9. The AdSS shall~~payor must~~ not deny a claim on the basis of lack of timely filing if the Provider~~provider~~ submits the claim within the timeframes listed in item 7 of this section~~above~~.

10. The AdSS shall adhere to ~~C~~claim payment requirements that pertain to both contracted and non-contracted Provider~~provider~~s.

C. DISCOUNTS~~**Discounts**~~

1. The AdSS shall ~~must~~ apply a quick pay discount of 1% on acute hospital inpatient, outpatient, and freestanding emergency department claims paid within 30 days of the date on which the ~~C~~clean ~~C~~claim was received.

2. The AdSS shall apply quick pay discounts to any acute hospital inpatient, outpatient, and freestanding emergency department claims billed on a CMS 1450 (UB-04) claim form.

D. INTEREST PAYMENTS~~**Interest Payments**~~

1. The AdSS shall ~~must~~ pay interest on late payments and report the interest as directed in the Division Encounter Manual and the DDD Claims Dashboard Reporting Guide. ~~required~~.

2. ~~For hospital, clean claims, T~~the AdSS shall ~~must~~ pay slow payment penalties or ~~(~~interest~~)~~ on payments made after 60 days of receipt of the hospital ~~c~~Clean C~~c~~laim as follows:~~.~~

   a. The AdSS shall pay i~~I~~nterest ~~must be paid~~ at the rate of 1% per month for each month or portion of a month from the 61st day until the date of payment.

   b. The AdSS shall apply slow pay penalties or interest to any acute hospital inpatient, outpatient, and freestanding emergency department claims billed on a CMS 1450 (UB-04) claim form.

3. The AdSS shall pay interest on payments made after 30 days of receipt of a Clean Claim f~~F~~or authorized services submitted by a licensed skilled nursing facility as follows:~~,~~ ~~the AdSS must pay interest on payments made after 30 days of receipt of the clean claim.~~

a. ~~I~~interest is paid ~~a~~At the rate of 1% per month; and

b. ~~(p~~Prorated on a daily basis~~)~~ from the date the C~~c~~lean C~~c~~laim is received until the date of payment.

4. The AdSS shall, ~~F~~for non-hospital C~~c~~lean ~~c~~Claims, ~~the AdSS must~~ pay interest on payments made after 45 days of receipt of the C~~c~~lean C~~c~~laim as follows:~~.~~

a. ~~Interest is paid a~~At the rate of 10% per annum; and

b. ~~(p~~Prorated daily~~)~~ from the 46th day until the date of payment.

5. The AdSS shall ~~must~~ pay interest on all claim disputes as appropriate based on the date of the receipt of the original C~~c~~lean C~~c~~laim submission, ~~(~~not the claim dispute~~)~~.

E. ELECTRONIC PROCESSING REQUIREMENTS~~**Electronic Processing and Remittance Advices**~~

~~A~~1. The AdSS shall ~~must~~ accept and generate required HIPAA-compliant electronic transactions from or to any Provider~~provider~~ or their assigned representative interested in and capable of electronic submission of:~~.~~

a. ~~Accepted electronic submissions include e~~Eligibility verifications~~;~~,

b. C~~c~~laims~~;~~,

c. ~~c~~Claims status verifications; and

d.~~, and~~ P~~p~~rior authorization requests~~;~~. or

e. The receipt of electronic remittance.

2~~B~~. The AdSS shall~~must~~ make claim payments via electronic funds transfer (EFT).

3. The AdSS shall ~~and~~ accept electronic claim attachments.

F. REMITTANCE ADVICES

1~~C~~. The AdSS shall~~must~~ generate an electronic remittance advice advice related to the payments or denials to Provider~~providers~~ that includes at a minimum:

a~~1~~. The reason~~s~~~~(s)~~ for denials and adjustments;

b2. A detailed explanation /or description of all denials and adjustments;

c3. The amount billed;

d4. The amount paid;

e5. -Application of cCoordination of bBenefits (COB) and copays;

f6. Providers rights for claim disputes;

g7. Detailed Iinstructions and timeframes for the submission of claim disputes and corrected claims;. and

h. A link or supplemental file where claims dispute or corrected claims submission information is explained.

2D. The AdSS shallmust send the electronic remittance advice with the payment, unless the payment is made by EFT. The AdSS must either direct providers to the link where this information is explained or include a supplemental file where this information is explained.

3. The AdSS shall send Aany remittance advice related to an EFT to the Providerprovider is sent no later than the date of the EFT.

G. GENERAL CLAIMS PROCESSING REQUIREMENTS~~General Claims Processing~~

~~The AdSS must follow all general claims processing requirements as described below.~~

1~~A~~. The AdSS shall~~must~~ use nationally recognized methodologies to correctly pay claims, including:~~; these methodologies include but are not limited to:~~

a~~1~~. National Correct Coding Initiative ~~(NCCI)~~ for p~~P~~rofessional, a~~A~~mbulatory s~~S~~urgery c~~C~~enters, and o~~O~~utpatient s~~S~~ervices;

b~~2~~. Multiple p~~P~~rocedure or ~~/S~~surgical r~~R~~eductions; and

c~~3~~. Global d~~D~~ay evaluation and management ~~E & M~~ b~~B~~undling s~~S~~tandards.

2~~B~~. The AdSS shall ensure that the claims payment system ~~must~~ assess and apply data-related edits including: ~~but not limited to:~~

a~~1~~. Benefit p~~P~~ackage v~~V~~ariations,

b~~2~~. Timeliness s~~S~~tandards,

c~~3~~. Data a~~A~~ccuracy,

d4. Adherence to Division and AHCCCS policy,

5e. Provider qQualifications,

f6. Member eEligibility and eEnrollment, and

g7. Overutilization sStandards.

3C. If a claim dispute is overturned, in full or in part, tThe AdSS shall, if a claim dispute is overturned in full or in part, reprocesses and pays the claim(s):

a. Iin a manner consistent with the decision; and

b. wWithin 15 business days of the decision.

4D. The AdSS claims payment system shall must not require a recoupment of a previously paid amount when:

a. Tthe Providerprovider's claim is adjusted for data correction, (excluding payment to a wrong Providerprovider;) or

b. aAn additional payment is made.

5. The AdSS shallmust ensure submit encounters are submitted in accordance with Division and AHCCCS standards and thresholds.

6~~E~~. The AdSS shall~~must~~ adhere to the following requirements when processing claims:

a~~1~~. COB and t~~T~~hird p~~P~~arty l~~L~~iability requirements per contract, and Policy 201 and 434 in the Division's Operations Manual;

~~2~~b. Claims processing requirements per contract and the DDD Claims Dashboard Reporting Guide;

c. Claims recoupments and refunds requirements per contract, Division Operations Policy 412, and the DDD Claims Dashboard Reporting Guide; and

~~3~~d. All Health Insurance, Portability, and Accountability Act (HIPAA) requirements according to 45 C.F.R. §§ Parts 160, 162, and 164.

~~F~~5. The ~~When the~~ AdSS, when cost avoiding ~~contractor cost avoids~~ a claim, shall apply the following payment provisions ~~apply~~:

a~~1~~. Claims from Provider~~provider~~s contracted~~CONTRACTED~~ with the AdSS: ~~Unless a subcontract with the provider specifies otherwise,~~ T~~t~~he AdSS shall~~must~~ pay the

difference between the AdSS cContracted Rrate and the pPrimary iInsurance Ppaid amount, not to exceed the AdSS cContracted rRate.

b2. Claims from Providerproviders not contractedNOT CONTRACTED with the AdSS: The AdSS shallmust pay the difference between the AHCCCS cCapped-fFee-fFor-sService rate and the pPrimary iInsurance Ppaid amount, not to exceed the AHCCCS Ccapped-Ffee-Ffor Sservice.

H. CLAIMS PROCESSING BY THE AdSS ~~Claims Processing By AdSS Contractors~~

1A. The AdSS shallmust requestobtain prior approval from the Division for obtaining subcontracts for regarding claims processing to be performed by or under the direction of a subcontractor.

2B. The AdSS shall remainremains responsible for the complete, accurate, and timely payment of all valid Providerprovider claims arising from the provision of medically necessary covered

services to its enrolled Mmembers regardless of administrative service arrangements.

3C. The AdSS shall must forward all claims received to the subcontractor responsible for claims adjudicationadjudicating.

4D. The AdSS shallmust require the subcontractor that processes claims to submit a monthly claims aging summary to the AdSS to monitor ensure compliance with claims payment timeliness standards.

E5. The AdSS shallmust monitor the payment processing subcontractor's performance on an ongoing basis and complete a formal review according to a periodic schedule.

6. The AdSS shall, upon completing the formal performance review of the payment processing subcontractor:

a1. As a result of the performance review, any deficiencies must be Ccommunicated any performance deficiencies resulting from the review to the subcontractor;

b. Establish in order to establish a corrective action plan to address the deficiencies; and.

c~~2~~. Provide ~~T~~the results of the performance review and the correction plan ~~must be communicated~~ to the Division upon completion.

6~~F~~. The AdSS shall~~must~~ monitor encounters received from the subcontractor to ensure encounters are submitted in accordance with Division and AHCCCS standards and thresholds.